TODAY'S DATE: _______/_______/_______ SS# _______-_______-_______ GENDER: ☐ MALE ☐ FEMALE

NAME: ____ DATE OF BIRTH: _________/_________/_________
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP CODE)

PHONE NUMBERS: (HOME) _________________ (WORK) _________________ (CELL) _________________

EMAIL ADDRESS: ____________________________ MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D

OCCUPATION: _____________________________ PATIENT EMPLOYER: ____

WHO REFERRED YOU TO OUR OFFICE? (PLEASE FILL IN BELOW):

DOCTOR: ___________________________ PATIENT: ___________________________ OTHER: ______________________

EMERGENCY CONTACT: ______________________________________

RELATIONSHIP TO PATIENT: __________________________ TELEPHONE NUMBER: ________________________

PRIMARY INSURANCE CARRIER INFORMATION:

NAME OF COMPANY:_______________________________

POLICY #____ GROUP# ____

SUBSCRIBER NAME (if not self) ____

Subscriber SS#_________-_________-_________ Subscriber D.O.B._________/__________/_________

SECONDARY INSURANCE CARRIER:

NAME OF COMPANY:_______________________________

POLICY #____ GROUP# ____

SUBSCRIBER NAME (if not self) ____

Subscriber SS#_________-_________-_________ Subscriber D.O.B._________/__________/_________

MEDICAL INTAKE SHEET

WHAT KIND OF PROBLEMS ARE YOU HAVING WITH YOUR EYES? ____

____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, WHICH ONES? ____

____

____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?	YES	NO
Arthritis or Rheumatoid Problems	☐	☐
AIDS/HIV	☐	☐
High Blood Pressure	☐	☐
Neurological Disease	☐	☐
Blood Disorders	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Collagen Vascular Disease	☐	☐
Migraines	☐	☐
Heart Disease	☐	☐
Thyroid Disease	☐	☐
Recent Weight Gain	☐	☐
Recent Weight Loss	☐	☐

Do you smoke? ☐ YES ☐ NO How often?______________ Do you use alcohol? ☐ YES ☐ NO How often? ___________

Do you use exercise? ☐ YES ☐ NO How often?______________

Female patients: Are you pregnant? ☐ YES ☐ NO Are you nursing? ☐ YES ☐ NO

HAS ANY MEMBER OF YOUR FAMILY HAD OR CURRENTLY HAVE?	YES	NO
Arthritis	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Glaucoma	☐	☐
Hypertension	☐	☐

HAVE YOU HAD OR CURRENTLY HAVE?	YES	NO
Cataracts	☐	☐
Detached Retina	☐	☐
Dry Eyes	☐	☐
Eye Injury	☐	☐
Floaters	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Diabetes	☐	☐

DO YOU WEAR CONTACT LENSES? ☐ ☐

IF YES, PLEASE CIRCLE TYPE: SOFT SOFT-TORIC RIGID GAS PERMEABLE (RGP) HARD

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: ____

____

____

I, the undersigned fully consent to the examination. I also acknowledge responsibility for the payment of all services. Unless I have arranged otherwise, I will pay for the services at my first office visit.

I understand there will be a $50.00 charge for missed appointments that are not cancelled at least 24 hours in advance. Additionally, I realize any non-covered services, co-payments and/or deductibles, not paid by the insurance plan, will be my responsibility.

Patient's signature: ____ Date:________/________/________

SO THAT WE MAY HONOR YOUR PRIVACY, PLEASE ANSWER THE FOLLOWING QUESTIONS

May we telephone or leave a message on your home answering machine? ☐ YES ☐ NO
May we leave a message at your place of employment? ☐ YES ☐ NO
May we discuss your medical condition with a family member? ☐ YES ☐ NO

*If yes, name of family member: _____________________________________ Relationship: ____________________________

Patient's signature: ____ Date: _______/_______/_______

FOR PATIENTS WITH INSURANCE COVERAGE ONLY:

I request that payment of authorized Medicare, Medigap, or other insurance company benefits be made to Eric R. Mandel, M.D., P.C., on my behalf, for any services furnished to me by the provider. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents and the Centers for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient's signature: ____ Date: _______/_______/_______